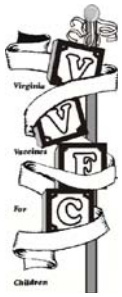

VVFC VACCINE ACCOUNTABILITY REPORT

PIN _____ **Report Month & Year** _____

Practice _____ **Contact** _____

Address _____ **Phone** ( ) _____

_____ **Fax** ( ) _____

TEMPERATURES	
REFRIGERATOR	
	°F / °C *(please circle)*
FREEZER	
	°F / °C *(please circle)*

INSTRUCTIONS:

- Record the number of doses administered to VVFC eligible patients or free vaccine eligible patients in the middle column. You may use tally marks throughout the month; however, remember to put the numeric total in the designated column before submitting.
- Conduct a physical vaccine inventory at the close of business the last day of month, indicating the date it was conducted. Do not include private vaccine stock. Do not list lot numbers. Estimate the number of doses in any opened, multi-dose vials.
- At the time of inventory, record storage temperatures in the top right-hand corner of form.
- Any expired or wasted vaccine should be included in your inventory UNLESS YOU ALREADY REPORTED it on a VVFC Return Form. **Do not report expired or wasted vaccine via VVFC Return Form on the same day you conduct an inventory,** as it might be deducted twice if you excluded it when you conducted your inventory.
- Obtain signature of your VVFC main contact (usually the physician who signed the contract) and submit to our office.

VACCINE	DOSES ADMINISTERED (Tally Marks Optional)	TOTAL	ENDING INVENTORY Date Conducted: _____
DT (Pediatric, High Risk)			
DTaP			
DTaP-Hep B-IPV (Pediarix)			
DTaP-Hib (Trihibit)			
Hepatitis A			
Hepatitis B (3 dose series)			
Hepatitis B 2-dose (Adolescent)			
Hib			
Hep B-Hib (Comvax)			
HPV			
Influenza (6 months-35 months)			
Influenza (36 months-18 years)			
Influenza LAIV (FluMist)			
IPV (Polio)			
MCV4 (Meningococcal Conjugate)			
MPSV4 (Mening Polysaccharide)			
MMR			
MMR-Varicella			
PCV-7 (Pneumococcal Conjugate)			
PPV-23 (Pneumo Polysaccharide)			
Rotavirus			
Td (Adolescent / Adult)			
Tdap (Adolescent/Adult)			
Varicella (Chickenpox)			
Other Vaccines:			

On behalf of myself and the practitioners associated with this facility, agree that the data above are accurate to the best of my knowledge. _____

VVFC Physician Contact Signature Date

Division of Immunization, P.O. Box 2448
109 Governor Street, Room 314 West
Richmond, VA 23218

Phone (800) 568-1929
(804) 864-8055
Fax (804) 864-8090 or 8089

01/23/2007, Public Facilities

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